STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 17,518
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Prevention, Assistance, Transition, and Health Access (PATH) terminating his Vermont Health Access Program (VHAP) benefits. The issue is whether the petitioner should be disqualified because he has other insurance.

FINDINGS OF FACT

1. The petitioner and his wife filed a VHAP application in December of 2001 and were found financially eligible based on their monthly income from self-employment of $1,492. They began receiving the benefit in that month. Shortly thereafter during an administrative review of their application, PATH noticed that the petitioner had reported that he had other insurance on his application, a fact which its worker missed during the previous eligibility determination.

2. The petitioner and his wife purchase annual private health insurance which commenced on September 1, 2000 and which was renewed on September 1, 2001. (The insurance is not

employer-sponsored.) The petitioner's health insurance covers a wide range of hospital and physician services but does not include coverage for many items that are paid by VHAP, such as preventative health care. The insurance also has deductibles and maximums which are not found in the VHAP program. For example, the petitioner and his wife must meet an annual deductible of $3,500 each; specific benefits are capped as to payments amounts; and overall benefits are limited to a cap of $250,000 per year and $1,000,000 in a lifetime.

3. The petitioner pays $2,573.70 per year as an annual premium for this insurance. He has been making the premium payments from the proceeds of a gift made to him by his mother. This year’s premium is completely paid for through August of 2002.

4. PATH notified the petitioner and his wife on January 2, 2002 that they would no longer be eligible for VHAP benefits effective February 1, 2002 because they have other insurance.

5. The petitioner appealed and has continued to receive benefits pending the outcome of this hearing. The petitioner was advised to get an attorney with regard to this issue and the matter was held open for a month in order to allow him to

obtain counsel. However, no counsel appeared for the petitioner in this matter.

ORDER

The decision of the Department is affirmed.

REASONS

The Vermont Health Access Plan was adopted in order to expand Medicaid-type health coverage to "uninsured low-income Vermonters" whose income and resources are above traditional Medicaid financial limits. W.A.M. 4000. Under the regulations adopted by PATH, an individual may be eligible for VHAP benefits if he is either "uninsured" or "underinsured". W.A.M. 4001.2. These definitions are met for an individual only if "he/she does not qualify for Medicare" and "does not have other insurance that includes both hospital and physician services".[1] W.A.M. 4001.2. The petitioners are not Medicare beneficiaries but they do have private insurance. That insurance does cover both hospital costs and physician's

[1] This section also defines an "uninsured person" as one who has not had insurance for the last twelve-months with certain exceptions for persons who lost employer-sponsored insurance. W.A.M. 4001.2. The Board has declared that this provision is void because it violates the Medicaid waiver given to the state but thus far the Secretary has declined to adopt that ruling. See Fair Hearing No. 16,748. This provision is not at issue

services. As such, the petitioners do not meet the definition of “uninsured” or “underinsured” found above. If they do not meet this requirement, they cannot be eligible for the VHAP program. W.A.M. 4001.2.

The petitioner makes two arguments against the imposition of this regulation. The first is that the medical benefits from the private insurance must be the same as those found in the VHAP program in order to exclude him from VHAP. The second is that he is being penalized for being responsible and purchasing health insurance while others in his position can spend their money on other things and still be eligible for benefits.

No legal authority was offered by the petitioner to support his objections and there is certainly nothing in the state law and regulations or federal statutes that would explicitly support his contentions. The petitioner may be correct these requirements are unfair to him but that does not mean that they are illegal. The state makes laws and regulations that do treat people differently. It is permissible for the state to do so if it has a rational basis for so doing. In this case, the state has determined that it

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in this case since the petitioner has insurance and will continue to have it for several more months.

will use its limited funding to assist only persons who have no or very minimal insurance coverage. Persons who have opted to provide insurance for themselves that include some level of physician and hospital coverage are deemed to be not in need of state assistance. This group may not have equal coverage with state-assisted persons or may have acted more responsibly than the others in purchasing health insurance but it cannot be said that these facts makes the state's decision unreasonable. Reasonable and fair are not always the same thing. A state's plan may not be perfect but if it is reasonable and meets its stated legal objectives then it cannot be overturned because it is not equally fair to everyone.

As the Department's decision denying VHAP coverage to the petitioner and his wife is in accordance with its legally adopted regulations, the Board is bound to uphold that decision, even if it disagrees with the result. 3 V.S.A. § 3091(d), Fair Hearing Rule 17. The petitioner is strongly urged to speak to his caseworker and an attorney if he is considering dropping his health insurance at the end of the year to see if such a suspension would be disqualifying.

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